MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
NOVEMBER 25, 1997 SPECIAL MEETING MINUTES

Adopted by the Task Force on January 5, 1998.

Tuesday November 25, 1997
8:30 A.M. - 5:15 P.M.
1400 J Street, Room 204
Sacramento Convention Center
Sacramento, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 8:45 A.M.

The ninth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by the Chairman, Dr. Alain Enthoven, at the Sacramento Convention Center in Sacramento, California.

II. ROLL CALL

Task Force Administrative Assistant Lawrence Ahn took roll. The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Barbara Decker; Alain Enthoven, Ph.D.; Ms. Nancy Farber; Ms. Jeanne Finberg; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. Clark Kerr; Mr. Terry Hartshorn; Mr. Bill Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Peter Lee; Dr. J.D. Northway; Mr. John Perez; Mr. John Ramey; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Mr. Les Schlaegel; Ms. Ellen Severoni; Dr. Bruce Spurlock; Mr. David Tirapelle; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following alternate members were also present: Dr. William Duffy, substituting for Hon. Martin Gallegos, and Mr. David Grant, sitting in for Ms. Maryann O'Sullivan.

The following ex-officio members were present: Ms. Marjorie Berte; Mr. Michael Shapiro and Dr. David Werdegar.

III. OPENING REMARKS - 9:00 A.M.

Chairman Enthoven welcomed Task Force members and the public and thanked them for participating in the third of a series of three day meetings scheduled to ensure all papers drafted by Expert Resource Groups and staff are afforded an opportunity to be discussed before they are scheduled for formal adoption. Chairman Enthoven then introduced Task Force Executive Director Phil Romero.

Mr. Romero echoed the Chairman's appreciation that members put some much effort into ensuring the three day meetings were productive. He then announced that Mr. David Grant would be sitting in for Ms. Maryann O'Sullivan and that Dr. William Duffy would be sitting in for Hon. Martin Gallegos.

Dr. Romero also stated the Task Force would not be voting formally on any issues today.

IV. OLD BUSINESS - 9:15

A. Discussion Of The Practice Of Medicine Paper (Task Force member Dr. Bernard Alpert and Dr. Bruce Spurlock).

Dr. Alpert and Dr. Spurlock presented the recommendations from the practice of medicine paper to the Task Force. After each recommendation was discussed, Task Force members conducted straw votes.

Recommendation 1 (A,B,C, D, and E) concerned changes in the prior authorization/concurrent review process, including broader use of provider pre-credentialing and "gold carding". 1A was revised as a directive to the Legislature and Governor to encourage health plans to adopt the noted changes, rather than encouraging the changes through purchaser contracts. 1B was not revised. 1C was revised to allow a two year probationary for health plans to assess providers for pre-authorization eligibility. 1D was revised to clarify for which conditions (those for which outcomes-based protocols have been developed and accepted) the prior authorization/
concurrent review process should be eliminated. 1E was not revised. After discussion, Recommendation 1 was supported by a majority of Task Force members.

Recommendation 2 concerned changes to drug formulary management. Dr. Spurlock stated that the idea behind this recommendation was to streamline the process for the patient and the physician when they are trying to decide which drugs make the most sense for their clinical condition. It recommended that all health plans that offer prescription drug benefits and use a formulary must periodically publish their formulary list and make it available to any member of the public upon request; that health plans publish the process by which the formulary is developed and reviewed; and that when a health plan removes a drug from the formulary, they must allow the patient to continue receiving the removed drug for an ongoing condition unless the treating physician changes the prescription.

Vice Chairman Kerr suggested replacing the paper's Recommendation 2A through 2E with Mr. Lee's proposed Recommendation 2A through 2E (distributed to Task Force members by Mr. Lee). Mr. Lee's proposed Recommendation 2 received majority support.

Chairman Enthoven stated that the intent of Recommendation 3, regarding liability, was that there should be one legal action and that if a determination of liability was reached, the parties should contribute to the extent of their negligence and liability. Substitute language specifying health plans, medical groups, hospitals, etc. - rather than "all entities practicing medicine" - was incorporated to avoid confusion with the issue of the corporate practice of medicine. The majority of Task Force members voiced support for the intent of Recommendation 3, with exact wording to be determined.

Recommendation 4 concerned the creation of a blue ribbon panel to study and recommend standardized definitions of terms, such as "medically necessary", used in health coverage contracts. Mr. Grant provided Task Force members with three additions to Recommendation 4A, regarding: 1) decisions of coverage equal decisions of care; 2) benefit decision should take into account particular needs of particular populations, specifically the elderly and disabled, and focus on maximizing functional capacity; and 3) impacts on quality of care should be considered. These additions were included in the list of issues for the blue ribbon panel to consider. Recommendation 4A received majority support. Ms. Farber requested that Recommendation 4B be amended to include the new regulatory oversight agency in the blue ribbon panel. Recommendation 4B as amended was supported by the majority of Task Force members.

PUBLIC COMMENT

1. **Ms. Maureen O'Haren -**California Association of Health Plans Ms. O'Haren stated that health plans can only gold card somebody for those procedures for which there are clear objective guidelines in place, so she asked the Task Force to collapse Recommendations 1C and 1D. She also suggested that pre-authorization cannot be eliminated entirely because even when a physician has been gold carded, the physician needs to call the health plan to check for eligibility, verify coverage for that particular benefit, and make sure that the setting is appropriate.

2. **Ms. Beth Capell -**Health Access Ms. Capell called the attention of the Task Force to two points: 1) practice guidelines and clinical pathways ought to be developed by practicing health professionals, including nurses; and 2) these guidelines should be available not only to the patient and the treating health professional, but also for review by consumer groups and relevant health professionals specialty associations.

B. Discussion Of The Dispute Resolution Paper- (Task Force Members Mr. Peter Lee and Ms. Barbara Decker) - 2:30 P.M.

Ms. Decker began by reviewing the "essential elements" of the dispute resolution process, including the need for consumers to understand their rights and responsibilities; quick resolution; assistance in navigating the system; fairness; efficiency; and feedback loops to improve the system.

Ms. Decker and Mr. Lee then reviewed, led discussion, and conducted straw votes on each recommendation. Recommendation A1 encouraged the use of collaborative and non-repetitive processes to improve dispute resolution. Recommendation A2 encouraged voluntary adoption of the recommendations for those employer-based plans that are exempted from state regulation under ERISA. Task Force members did not object to these two items.

Section C concerned standardization of timeframes in the dispute resolution process. Mr. Lee reordered the items so that C(g) - a recommendation that where the medical group is acting on behalf of the health plan, all dispute resolution standards that would have applied to the plan now apply to the medical group - became C(a). He also clarified that the main differences between the recommendations and existing law were that in the recommendations 1) these timeframes should apply across all plan types, including PPOs and 2) plans should resolve disputes over emergency situations in 72 hours rather than 5 days. In addition, Mr. Lee stated that the intent of the recommendations is to have closure on disputes within the timeframes, except in rare circumstances. The recommendation regarding the 72 hour rule was amended to have the state regulatory agency study and consider making the shorter timeframe the standard in two years. The recommendation regarding the period of limitation within which a patient can file a grievance was amended to encourage uniformity across plans without specifying the precise length of time. Other recommendations discussed included standardization of terminology and data collection, and communication of dispute resolution processes. The recommendations concerning explanations of health plans' decisions was amended to include language to preserve the peer review process. Task Force members did not object to any of these recommendations, as amended.

The Task Force next discussed recommendations regarding consumer empowerment. On the issue of second opinions, the recommendation was clarified to encourage second opinions within the patient's medical group or network unless the particular expertise for the patient's condition does not exist within the network, in which case the plan should pay for a second opinion outside the network. These recommendations as amended were accepted without objection.

Recommendation 5, concerning consumer assistance through plans, was amended to state that physicians can serve as an important patient advocate, to allow for disputes between patients and physicians. Recommendation 6 was amended to encourage member participation in the appeals process, either in person or by teleconference. Recommendation 7, regarding external sources for consumer assistance, was amended to encourage funding through private foundations and to create pilot projects. Consideration of extending the range of assistance through litigation was also added.

Recommendation G was revised to encourage formation of a collaborative process with all major stakeholders to develop an independent third party review process providing consumers and plans with an unbiased, expert review of grievances pertaining to medical necessity. Chairman Enthoven and Dr. Karpf also agreed to write a recommendation that would create a process for developing authoritative standards used in the third party review process. These recommendations were accepted without objection. Mr. Shapiro's recommendation regarding ERISA was also accepted without objection. Mr. Gallegos' recommendations regarding arbitration were tabled until the next Task Force meeting.

PUBLIC COMMENT

1. **Ms. Maureen O'Haren -** California Association of Health Plans Ms. O'Haren made two comments. First, she said that current law should be stated wherever it is relevant. Second, she stated that data elements should not be specified; the regulator should determine how best to provide information to the public on grievances.

2. **Ms. Clare Smith -** California Health Insurance Counseling and Advocacy Program Ms. Smith requested that the HICAPs be included in the dispute resolution collaborative working group.

C. Discussion Of The Consumer Involvement, Communication And Information Paper - (Task Force members: Ms. Jeanne Finberg and Ms. Ellen Severoni) - 4:00 P.M.

Ms. Finberg stated that many consumers do not understand what managed care is, so information should be provided to them that describes what managed care is and how it works in California. She said this information should be available in the many languages being spoken in California. Health plans should also submit to the state agency major health conditions or illnesses that require referrals to specialty centers. Data on these conditions, where the patient received care and how many of these procedures were referred, would then be reported annually. This information would give consumers an idea of what happens when an individual gets sick, where he/she can go, and what services his/her plan includes.

Ms. Finberg also discussed creating a comprehensive directory of providers and their available networks within the plan or group. This directory would be kept updated on a continuous basis and would also be available on the Internet.

Ms. Severoni stated that health plans, based on the Knox-Keene Act, need to describe the mechanism by which enrollees can express their views on public policy matters. In addition, they must establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan and incorporate these procedures into the plans' by-laws.
Ms. Severoni recommended that plans establish a governing body composed of at least one-third members or enrollees and ensure that sufficient resources are made available to educate the enrollee board members so that they can effectively participate. This committee shall also communicate and advocate for members' needs and serve as a resource for the governing body and plan administrators. It shall establish mechanisms and procedures for enrollees to express their views and concerns. It should

include but not be limited to issues such as benefits and coverage, member communications, quality assurance, marketing and grievance resolution.

Public participation is not destructive, Ms. Farber said. There are 65 hospitals in California which have publicly elected members in their governing boards. Having the public participate has proven to be a very good morale booster. Dr. Alpert stated that about 40 percent of the medical board of California are consumers and this does work very well.

To clarify, Vice Chairman Kerr explained that plans would publicly have to disclose how many members/enrollees with no financial interest in the corporation are on their governance bodies. This information, along with other information, would be available for consumers to consider when choosing their health plan.

A straw vote was taken and all the recommendations presented by Ms. Finberg and Ms. Severoni were majority accepted by the Task Force.

PUBLIC COMMENT

1. **Ms. Maureen O'Haren -**California Association of Health Plans Ms. O'Haren questioned whether members/enrollees would read all the information that would be readily available. She stated that health plans hold some information as private property and would not want to disclose it to an enrollee. She also stated that the medical board currently has an Internet site that provides "super-directory" information. Finally, Ms. O'Haren recommended that the Department of Corporations should also be required to indicate what action it took in response to complaints.

2. **Ms. Catherine Dodd -**American Nurse Association of California Ms. Dodd urged the Task Force to pursue the superdirectory idea as a means of improving the market. In response to health plan claims that providing information would increase their costs, Ms. Dodd suggested that health plans stop giving away marketing materials such as pens and pencils during open enrollment events.

D. Discussion Of Integration: A Case Study Of Women Paper - (Task Force member: Dr. Helen Rodriguez-Trias) - 4:30 P.M.

Dr. Rodriguez-Trias began her presentation stating that women are the primary consumers of health care for themselves and their families. As such they are the most affected by some of the issues around fragmentation of services, because traditionally reproductive health services have been provided as a separate part of the health care system. Thus the Task Force should encourage managed care organizations to coordinate and integrate care around the needs of its members.

Dr. Rodriguez-Trias further stated that health plans should recognize that members, women in particular, are likely to forgo care because of scheduling and confidentiality issues. Therefore, managed care organizations should address these issues systematically. Managed care organizations (MCO's) should ensure that their primary care practitioners or teams are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. She stated that MCOs should also be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exams, contraceptive management, and initial management of common gynecological problems.

Dr. Rodriguez-Trias also stated that women should be allowed direct access to their reproductive health providers. In addition, plans should offer coverage for a full range of reproductive health services

including fertility control, sexually transmitted diseases (prevention, detection, and treatment), and family planning methods. Finally, she suggested collaboration between the public and private sector in the development of consistent standards and evidence-based, gender-specific practice guidelines.

PUBLIC COMMENT

1. **Ms. Maureen O'Haren -**California Association of Health Plans Ms. O'Haren said that current law requires health plans to provide all medically necessary services, to maintain confidentiality, and to provide a variety of family planning services, therefore the paper's recommendations on those issues are unnecessary. She also stated that encouraging plans to provide information directly to all plan enrollees could be a costly mandate. She further argued that 93% of consumers are currently enrolled in a plan that provides some form of direct Ob/Gyn access.

2. **Ms. Betty Perry - Older Women's League** Ms. Perry commented that no recommendation mentioned any way to deal with the mental health needs of women.

3. **Mr. Jim Randlett -**California Association of Obstetricians and Gynecologists Mr. Randlett argued for direct access to Ob/Gyn providers. He stated that, contrary to what Ms. O'Haren said, closer to 50% of women in California have true direct access.

V. ADJOURNMENT [Vice Chairman Kerr) - 5:15 P.M.

Without objection, Vice Chairman Kerr declared the Special Meeting adjourned at 5:15 p.m.

Prepared by Enrique J. Ramirez, Ph.D.